INTRODUCTION

Case Study

John is a 59-year-old man who lives in a group home in Maine. He is tall, wears glasses, and sports a beard. He is shy and gentle with a good sense of humor. Three days a week, he attends a Clubhouse where he goes to the morning house meeting and then helps out in the café or snack bar. On Wednesday night, he attends choir practice at his church where he has made "a lot of friends." He has a girlfriend at the group home where he lives who "really cheers me up." He has been attending the Clubhouse for 10 years. He has several mental health diagnoses—clinical depression, bipolar disorder, and obsessive-compulsive disorder (OCD). He has had diabetes for a number of years, is on insulin and has his blood sugar checked daily at the facility where he lives. He recently started using a cane to compensate for a balance disorder, which, prior to using the cane, caused him to fall a lot. He rates his current health as very good and says a new medication for his depression has resulted in him feeling physically and mentally well for the past month. Because of his balance problem, he finds it difficult to exercise. He says he would like to have a salaried job, but because of his health conditions, "I can't do a lot of things that I used to be able to do." John does not have a driver's license. His parents are deceased, and he has some family about an hour away who used to visit him at Christmastime. However, John said he hasn't seen them for a long time.

(Names and other identifying information have been changed.)

Making the Case

Nationally and in Maine, people with diagnoses of Serious Mental Illness (SMI) die 25 years sooner than people who do not have diagnoses of SMI. They die of chronic diseases and not from their mental illnesses. People with diagnoses of SMI tend to live with more than one other chronic health condition, like diabetes and cardiovascular disease or chronic pulmonary disease (COPD) and arthritis. They also die from vaccine-preventable infectious diseases like the flu and pneumonia.[1]

Maine data shows that:

- 65.4 percent of MaineCare members under age 65, with a diagnosis of SMI, had five or more medical conditions; this compares to 24 percent for MaineCare members with no diagnosis of serious mental illness[2]
- 25 percent have been diagnosed with diabetes[3]
- 37 percent have pre-diabetes or metabolic syndrome[4]

As in the general public, cardiovascular disease causes most of the deaths in the SMI population. There are more deaths from heart disease than from suicide.[5] In Maine, people with SMI ages 18–65 are three times more likely to have coronary artery disease than those without SMI.[6] People with SMI get coronary artery disease at a younger age than those without a mental illness. They are also at greater risk of developing vascular

disease because of their high rates of diabetes. Unlike the general population, coronary artery disease rates for men and women with a diagnosis of SMI are equal. In the general population, men have higher rates.

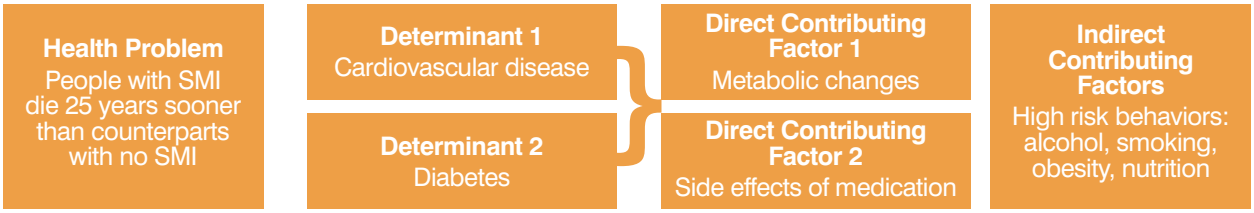
Many people with SMI also have higher rates of behaviors that put their health at risk. When compared to the general public, people with mental illness smoke more, are more overweight or obese, and exercise less. These factors are known to increase the likelihood of developing diabetes, heart disease, high blood pressure and other chronic health conditions.

> **"We continue to see people show up at the Emergency Department or primary care office and their complaints are dismissed as psychosomatic because they have a mental illness."**

Maine data shows that:

- 51.9 percent of people age 18–64 with SMI are obese
- 46.9 percent smoke[7]

In a public health framework, people with SMI would be considered a vulnerable, or health disparity, population. The problem would look like this:



Stigma also plays a role in preventing people with SMI from getting the health care they need. Some providers may be reluctant to treat them or may find the time it takes to deal with their more complex health needs too great. By collaborating with primary care, mental health agencies can help reduce stigma for their clients and find primary care physicians who are willing to partner with them.

THERE IS HOPE

Many of the health conditions that are associated with death in the United States and premature death in mental health consumers can be prevented and managed with positive health habits. If a person has already developed a chronic disease like diabetes, medication and ongoing monitoring from a trusted health care provider is critical. The level of disability from that chronic disease can be reduced with changes in nutrition, exercise, and other health habits.

THE MAINE MODEL

Six community-based mental health agencies in Maine participated in a three-year project funded by the Maine Health Access Foundation (MeHAF) through a grant to the Maine Department of Health and Human Services (DHHS) Office of Quality Improvement (OQI). They are:

- Common Ties Mental Health Services in Lewiston
- Crisis and Counseling Services in Augusta
- Kennebec Behavioral Health in Augusta
- MaineGeneral HealthReach ACT Team in Augusta
- Motivational Services in Augusta
- Tri-County Mental Health Services in Lewiston

In a fairly short amount of time and with limited funds, these mental health agencies have made tremendous strides in the following areas:

- Adopting a health screen for consumers with SMI
- Collecting data on consumers' health, exercise, health risk behavior, and relationship to primary care
- Supporting consumers in developing a long-term relationship with a welcoming primary care practice
- Training the mental health workforce on the health status and needs of consumers
- Collaborating with community resources such as the Cooperative Extension Service, Healthy Maine Partnerships, and food pantries
- Setting up diabetes education for staff
- Setting up diabetes education for consumers
- Adapting diabetes education and support models to better fit people with SMI

GIVING YOU SOME TOOLS IN YOUR TOOL BOX

This is a toolkit to help mental health agencies integrate health into their service settings. It addresses the following topics:

- How to bring health and wellness into agency culture
- How to use a health screen to assess people's health status
- How to involve and empower consumers in their health care
- How to link with community resources

It is divided into sections depending on your role within a mental health agency:

- Direct care staff
- Consumers
- Administration

Finally, there is a list of some Maine and national resources and websites.